STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G033	A. BUILDING 05/23/2014			
		100000	B. WING	A DDDDEGG OWN COLUMN CODE	00/20/2014	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE MARKET ST		
PATHFIN	IDER SERVICES II	NC	WABASH, IN 46992			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG W000000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
VV000000						
	This visit was fo	or a fundamental	W000000			
	recertification and state licensure survey.		11000000			
	receitification ai	nd state neensure survey.				
	Dates of Survey	: 5/13, 5/14, 5/15, 5/16,				
	5/20, 5/21, 5/22					
	3/20, 3/21, 3/22,	, and 3/23/2014.				
	Provider Numbe	nr. 15C022				
	Facility Number					
	AIM Number:	100233370				
	Surveyor:					
	Susan Eakright,	OIDP				
	Susan Lakingin,	QIDI				
	These federal de	eficiencies also reflect				
		accordance with 460				
	IAC 9.	decordance with 400				
	me).					
	Onality review o	completed May 30, 2014				
	by Dotty Walton	•				
	by Botty Walton	1, (151).				
W000104	483.410(a)(1)					
	GOVERNING BO					
	•	dy must exercise general				
	the facility.	d operating direction over				
	-	vation and interview, for 4	W000104	1. What corrective action(s) w	ill 06/22/2014	
		ents #1, #2, #3, and #4)	W 000104	be accomplished for these	00/22/2014	
	,	clients (clients #5, #6,		residents found to have been		
		ed in the group home, the		affected by the deficient	d	
		failed to exercise		practice: a. new vinyl order to repair 10/10 seats on dining		
				room chairs. b. vinyl seats		
		ion over the facility to		10/10 dining chairs will be		
	•	enance and repairs at the		replaced.2. How will you inder	ntify	
	group home.			other residents having the		
				1		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		15G033	B. WIN			05/23/	2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		456 W MARKET ST				
DATHEIN	IDER SERVICES IN	16			SH, IN 46992		
PATHEIN				WADAS	5H, IN 40992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include On 5/14/14 from and on 5/15/14 from 7:45am, observation period #5, #6, and #7 with dining room, kitted dining room tabled 4:45pm, ten of the chairs had split with very covering the ten Group Home States that the chairs nearly seat cushion edges against the sat down on the community of the Commu	: 3:19pm until 5:30pm rom 5:40am until tions were conducted at During both ods clients #1, #2, #3, #4, alked to access the chen, and sat at the e. On 5/14/14 at en (10/10) dining room rinyl seat cushions chair seats. At 4:45pm, aff (GHS) #3 indicated eded repair and the split ins exposed a rough vinyl e buttocks when people			potential to be affected by the same deficient practice and wh corrective action will be taken: a. 10/10 dining chavinyl seats will be replaced. b. Staff will infor Res. Mgr of any cracks in the chairs vinyl seats and pin a maintenance repair request as needed.3. What measures be put into place or what systematic changes you will move to ensure that the deficient practice does not recur: a. 10/10 dining room chairs vinyl seats will be replaced. b. Staff will inform Res. Mgr. of accracks in the chairs vinyl seats and put in a maintenance repair request as needed.4. How the corrective action(s) will be monitored to ensure the deficient practice wont recur, what quality assurant program will be put into place. a. Staff will inform Res. Mgr. of any cracks the chairs vinyl seats are put in a maintenance repair request as needed.5. What is the date by which the systemath changes will be completed: a. 6/22/14	irs m ut st will ake ny ill ace	
	9-3-1(a)				a. 0/22/17		
W000125		CLIENTS RIGHTS nsure the rights of all					
	clients. Therefore and encourage inc	, the facility must allow dividual clients to exercise nts of the facility, and as					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

685511

Facility ID: 000593

If continuation sheet

Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMP			COMPL	ETED
		15G033				05/23/2014	
			B. WIN		ADDRESS SITE STATE SID CODE		
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
DATUEL	IDED 0ED\//0E0 IA	10			MARKET ST		
PATHFIN	NDER SERVICES IN	NC		WABAS	SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	citizens of the Uni	ted States, including the					
	right to file compla	aints, and the right to due					
	process.						
	Based on observ	ation, record review, and	W0	00125	1. What corrective action(s) wi	II	06/22/2014
	interview, the fa	cility failed to develop			be accomplished for these	b	
	criteria for 1 add	litional client (client #7)			residents found to be affected the deficient practice: a. For	БУ	
		and utensils. The facility			clients #1-#4 as well as addition	nal	
	_	unimpeded access to			clients #5 & #6 in the home a		
		sampled clients (clients			goal will be created in their ISF		
	_	sampled cheffis (cheffis			ensure they have knowledge		
	#1, #2,				how to Access the Sharps in the	ne	
		two additional clients			home whenever they want fo		
	(clients #5 and #	6) who did not require			unimpeded access. b. For clie		
	restricted access	to sharps and utensils.			#7 a goal will be created in he		
					ISP to educate on the proper	use	
	Findings include	•			of sharps. c. Staff will be in-serviced on "What sharps a	ro"	
		•			to ensure that all sharps are	ic	
	On 5/14/14 from	2.10			locked up for safety of client		
		1 3:19pm until 5:30pm,			#7. d. #7 FATS will be updated	d to	
		6, and #7 were observed			include goal for proper sharps		
		ne and from 4:50pm until			use. e. Clients #1, #2, #3 and		
	5:30pm clients #	1, #2, and #5 were			FATS will be updated to include		
	observed at the g	group home. On 5/14/14			goal for sharps access.2. Ho		
	from 3:19pm un	til 5:30pm, client #7			you will identify other residents having the potential to be	5	
	prepared food in	the kitchen with the			affectedby the same deficient		
		ient #7 opened and			practice: a. For clients #1-#4	as	
	<u> </u>	ers to obtain a spoon to			well as additional clients #5 &		
		•			in the home a goal will be		
		ns cooking in pots on the			created in their ISP to ensure	they	
		cursed verbally at client			have knowledge of how to		
		r profane words. At			Access the Sharps in the ho	me	
	4:30pm, GHS (C	Group Home Staff) #2			whenever they want for	nt	
	used a sharp kni	fe he removed from a key			unimpeded access. b. For clie #7 a goal will be created in he		
	lock box on top	of the kitchen counter.			ISP to educate on the proper		
	_	ne knives were "locked"			of sharps. c. Any new client (s		
		t #7's "threats" to harm			moving into the the home will I		
					educated on how to access		
	starr and chents	inside the group home.			sharps in the home and have a	а	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		15G033	B. WING 05/23/20			2014	
		<u> </u>	D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹			MARKET ST		
DATHEIN	NDER SERVICES IN	NC			SH, IN 46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
		all" sharps were to be			goal to ensure they know how What measures will be put into		
	kept locked. On	5/15/14 from 5:40am			place or what systematic chan		
	until 7:45am, cli	ents #1, #2, #3, #4, #5,			you will make to ensure that th	-	
	#6, and #7 were	observed at the group			defienct practices does not	.	
	home. During b	oth observation periods			recur: a. goal will be created for	or	
	_	n sitting on the counter			client #1-#6 To educate how t		
		afe with sharp knives,			access sharps. b. In-service		
	· ·	rp objects inside. During			staff on what "sharps" consists		
		periods inside the			so all sharps are locked up. a to educate clients on	ıı IU	
		•			access. c. A goal will be creat	ed	
		er stored loose inside the			for #1-6 for how to access sha		
		our inch (4") bladed pizza			in home. d. A goal will be	•	
	· ·	vegetable peeler, and a			created for #7 to be educated	-	
	three and one ha	lf inch (3 1/2") bladed			proper uses of sharps. e. A	.II	
	knife. On 5/15/1	14 at 7:00am, GHS #1			new hires into home will be		
	stated "all" sharp	o objects were to have			in-services on the Sharps by Res. Mgr. or QDDP4. How the	ne	
	been locked inside	de the key safe for the			corrective action(s) will be		
		he clients because of			monitored to ensure the deficie	ent	
	client #7's threat				practice will not recur. what		
		5 01 11 4 11111			quality assurance program will		
	On 5/22/14 at 0:	30am, an interview with			put into place: a. Documentation	on	
					on #1-7 Sharps goals will be made daily by direct care star	_{ff}	
	the QIDP (Quali				on their goal sheets. b. Res M		
		essional) was conducted.			will monitor goal sheets to ens		
	_	ated facility staff should			documentation on Sharps go		
		at knives were kept			is bing completed by staff		
	secured and lock	ted after each use. The			monthly. c. Documentation on		
	QIDP indicated	the unsecured knife and			Sharps Goals will be review	.	
	sharp objects sho	ould not have been inside			monthly by QDDP.5. What is		
		rawer. The QIDP			date the systimatic changes w be completed: 6/22/14	"	
		actice of locked sharp			30 30111p10104. 0/22/17		
	_	addressed in the clients'					
	1 3	P indicated client #7 had					
		using sharp objects. The					
	1	• • •					
		clients #1, #2, #3, #4, #5,					
	and #6 did not ha	ave a identified safety					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G033	(X2) MULTIPI A. BUILDING B. WING	E CONSTRUC	TION	(X3) DATE COMPL 05/23/	ETED
	PROVIDER OR SUPPLIER		456	EET ADDRESS W MARKE BASH, IN 4		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC CROSS	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BI S-REFERENCED TO THE APPROPF DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
	that sharps were who lived in the indicated the pra objects was not a #2, #3, #4, #5, and indicated clients #5, and #6 would the sharps via sta On 5/23/14 at 9: 10/24/13 (Individual States of Stat	d need to gain access to aff. 23am, client #7's dual Support Plan) and avior Support Plan) 47's behaviors included ion, verbal aggression, nce. Client #7's BSP address [Client #7's] 1. Remove or lock up tent #7] could use to c) or others from the day program. [Client cissors and knives, so on these items but not to er sharp objects. When in use, ensure that staff are the items right away. In place for locked sharp afringe (sic) upon the esidents" Client #7's clude an objective/goal onsible methods to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

685511

Facility ID: 000593

If continuation sheet

Page 5 of 11

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 15G033	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2014			
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 456 W MARKET ST WABASH, IN 46992					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	5/20/14 at 12:00noon. Client #1's 5/30/13 ISP (Individual Support Plan) and 5/30/13 Functional Assessment Tool (FAT) did not indicate an identified need to lock sharp objects.						
	Client #2's record was reviewed on 5/21/14 at 11:30am. Client #2's 5/22/13 ISP and 5/2014 FAT did not indicate an identified need to lock sharp objects.						
	Client #3's record was reviewed on 5/16/14 at 12:50pm. Client #3's 9/6/13 ISP, 8/6/13 BSP, and 7/29/13 FAT did not indicate an identified need to lock sharp objects.						
	Client #4's record was reviewed on 5/21/14 at 12:15pm. Client #4's 9/19/13 ISP, 8/7/13 BSP, and 8/2013 FAT did not indicate an identified need to lock sharp objects.						
	9-3-2(a)						
W000242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

685511

Facility ID: 000593

If continuation sheet

Page 6 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G033	B. WIN			05/23/	/2014
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			MARKET ST		
PATHFIN	IDER SERVICES II	NC		l	SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	, ,	s been demonstrated that opmentally incapable of					
	acquiring them.	ортнентану пісаравіе от					
	_	ration, record review, and	l wo	00242	1. What corrective action(s) w	ill	06/22/2014
		of 1 sampled clients	'' "	002.2	be accomplished for these		00/22/2011
	-	was non verbal, the			residents found to have been		
	` ′	· ·			affected by the deficient		
		develop a training			practice: a. Create a communication goal for client	#3	
	program for con	imunication.			b. Create a PEC Picture Bind		
					to aid in communication with #		
	Findings include	· ·			c. Schedule a speech evalua		
					for #3 d. follow recommenda		
	On 5/14/14 from	n 3:19pm until 5:30pm			from Speech eval. e. In-servi		
	and on 5/15/14 f	from 5:40am until			staff on how to communicate	with	
	7:45am, client #	3 was non verbal. Client			#3 and on use of her PEC Picture Binder to help with		
	#3 stripped her of	clothing, walked naked			communication. And on gett	ina	
	inside her bedro	om with the door open,			eye contact with her before	3	
		hen, and refused the			signing. f. #3 ISP, FATS & E	SP	
	_	om 3:19pm until 5:30pm,			will be updated to include the		
		l verbal requests from			communication goal and PEC picture binder use as needed.		
		her clothing, did not			How will you identify other	۷.	
	_	ith facility staff, and no			residents having the potential t	to	
		•			be affected by the same defici		
	_	to communicate with			practice and what corrective		
		4:26pm until 4:55pm,			action will be taken: g. Hold II		
		ome Staff) #2 spoke to			meeting to discuss: the stripp incident by #3; review any	ing	
		id tone of voice directly			behavior reports on this behavior	/ior·	
		ask client #3 what she			determine what was being	,,,,	
		GHS #1 attempted to sign			communicated by this behavio		
	to client #3 and	did not gain eye contact			a. All new clients moving into	the	
	before signing th	ne words food and eat.			home who are non-verbal will	,	
	GHS #3 asked c	lient #3 to show her what			have a communication goal in the ISP. 3. What measures w		
	client #3 wanted	and offered client #3 her			be put into place or what		
	hand to hold. A	t 4:45pm, GHS #1, GHS			systematic changes you will m	nake	
		indicated client #3 was			to ensure that the deficient		
	-	he staff tried different			practices does not recur: a.		
	11011 VOIDUI UIIU I	no sain thea annoiont			Communication goal added to)	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		15G033	B. WIN			05/23/2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			MARKET ST	
PATHEIN	IDER SERVICES IN	NC.			SH, IN 46992	
					711, 114 40332	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	,	DATE
	1	nicate with client #3. At			ISP. b. Documentation on goa	
	4:45pm, client #	3 imitated contact with			sheets daily by DSP.4. How th corrective action(s) will be	e
	the surveyor and	took the surveyor by the			monitored to ensure the deficie	ent
	hand to walk the	n reach upward on the			practice will not recur, what	
		pantry to place the			quality assurance program will	be
	-	on a box of macaroni and			put into place: a. Documentat	ion
	cheese on the sh				on goal sheets daily. b.	
	cheese on the sh	C11.			Completion of goal	
	C1: #21	4			documentation be monitored monthly by Res Mgr.	
		d was reviewed on			c. Documentation will	
		pm. Client #3's 9/6/13			be reviewed by QDDP monthly	7.5 .
	ISP (Individual S	Support Plan), 8/6/13			Completed by: 6/22/14	,
	BSP (Behavior S	Support Plan), and			. ,	
	7/29/13 FAT (Fu	inctional Assessment				
	Tool) indicated s	she was non verbal and				
	did not include h	now staff were to				
		th client #3. Client #3's				
		lude a training program				
	_	3 to communicate her				
	wants and needs	•				
		30am, an interview with				
	the QIDP (Quali	fied Intellectual				
	Disabilities Prof	essional) was conducted.				
	The QIDP indica	ated client #3's plans did				
	not include a trai	ining objective to teach				
		municate her wants and				
		P indicated client #3 did				
		ng deficit and client #3				
		y the hand to show staff				
	what she desired	l.				
	9-3-4(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

685511

Facility ID: 000593

If continuation sheet Page 8 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			ETED		
		15G033	B. WIN		05/23		05/23/2014	
			D. (111)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER				MARKET ST			
PATHFIN	IDER SERVICES IN	IC			SH, IN 46992			
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL					COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
W000249	formulated a client each client must retreatment program interventions and a number and freque achievement of the individual program record review, for (client #7), the factient #7's BSP (was implemented opportunities existing include On 5/14/14 from clients #3, #4, #6 at the group home 5:30pm clients # observed at the group home facility staff. Client #7 was infected in facility staff. Client #3 and called her 4:30pm, GHS (Gused a sharp knift lock box on top of GHS #2 stated the facility staff was stated the facility staff of the food item stove. Client #7 was a sharp knift lock box on top of GHS #2 stated the facility staff of the food item stove.	erdisciplinary team has It's individual program plan, eceive a continuous active in consisting of needed services in sufficient ency to support the e objectives identified in fram plan. ation, interview, and or 1 additional client acility failed to ensure Behavior Support Plan) d to secure knives when ested.	Woo	00249	1. What corrective action will I accomplished for these reside found to be affected by the deficient practice. a. Staff will be in-serviced on #7 BSP focus on the need for sharps to be locked up and where the best of those sharps include so the safety of clients in the home. 2. How will you identify other residents having the potential to be affected by the same deficient practice and where the same deficient practiced on what all sharps include so that those sharps are secure for safety of clients in the home. What measures will be put into place or what systemic change you will make to ensrue that the deficient practices does not recur: a. Staff will be in-serviced and review #7 BSP, on need for sharps locked up. b. All new staff coming	nts f with ny. d that ed hat cus to . at ed e.3. co es ne on	06/22/2014	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

685511

Facility ID: 000593

If continuation sheet

Page 9 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SI	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	TED
		15G033	B. WIN			05/23/2	2014
		-		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		456 W I	MARKET ST		
	IDER SERVICES II	NC		WABAS	SH, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	work in the home will be trained	om	DATE
		inside the group home.			#7 BSP and documentation		
		'all" sharps were to be			on ABC charts by Res.	511	
	^	1 5/15/14 from 5:40am			Mgr. c. Staff will be		
		ients #1, #2, #3, #4, #5,			in-serviced on what all sharps		
		observed at the group			include so that those		
	home. During b	ooth observation periods			sharps are secured for safety of clients in the home.4. How will the	he	
	inside the kitche	en sitting on the counter			corrective action be monitored to		
	was a key lock s	safe with sharp knives,			ensure the deficient practice will	not	
	scissors, and sha	arp objects inside. During			recur, what quality assurance		
	both observation	n periods inside the			program will be put inot		
	silverware draw	er stored loose inside the			place: a. QDDP will update #		
	drawer were a fo	our inch (4") bladed pizza			BSP annually or as needed and gi to staff to review.5. What		
		vegetable peeler, and a			the date systematic changes will be		
	· ·	alf inch (3 1/2") bladed			complete: 6/22/14		
		14 at 7:00am, GHS #1					
		p objects were to have					
		ide the key safe for the					
		the clients because of					
	client #7's threat						
	Chent #/ Stillea	is of natifi.					
		23am, client #7's					
	10/24/13 (Indivi	idual Support Plan) and					
	5/8/14 BSP (Bel	havior Support Plan)					
	indicated client	#7's behaviors included					
	physical aggress	sion, verbal aggression,					
	and non complia	ance. Client #7's BSP					
		address [Client #7's]					
		1. Remove or lock up					
		ient #7] could use to					
	_	ic) or others from the					
	`	day program. [Client					
		scissors and knives, so					
	_						
	_	d on these items but not to					
	exclude (sic) oth	ner sharp objects. When					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

685511

Facility ID: 000593

If continuation sheet Page 10 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) l	MULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED		
	15G033	B. WI			05/23/	/2014		
NAME OF F	PROVIDER OR SUPPLIER	•		ADDRESS, CITY, STATE, ZIP CODE				
PATHFINDER SERVICES INC			456 W MARKET ST WABASH, IN 46992					
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ON SHOULD BE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	these items are in use, ensure that staff							
	monitor and secure the items right away.							
	There is a plan in place for locked sharp							
	items as not to infringe (sic) upon the							
	rights of other residents"							
	On 5/23/14 at 9:30am, an interview with							
	the QIDP (Qualified Intellectual							
	Disabilities Professional) was conducted.							
	The QIDP indicated facility staff should							
	have ensured that knives were kept							
	secured and locked after each use. The							
	QIDP indicated the unsecured knife and							
	sharp objects should not have been inside							
	the silverware drawer.							
	the silver ware drawer.							
	9-3-4(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

685511

Facility ID: 000593

If continuation sheet

Page 11 of 11